DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 - 0 0 6

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932 of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY '03 $ Budget
b. FFY '04 $ Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Table of Contents - page i
pages 9c - 9f

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Table of Contents - page i

10. SUBJECT OF AMENDMENT:
STATE OPTION FOR MANAGED CARE

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark Trail

13. TYPED NAME: Mark Trail

14. TITLE:
Director, Division of Medical Assistance

15. DATE SUBMITTED:

16. RETURN TO:
Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
November 15, 2002

18. DATE APPROVED:
February 11, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Ronald L. Murray for Rhonda Cottrell

21. TYPED NAME:
Rhonda R. Cottrell

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

Approved with the following correction to HCFA-179:

Item 8. as reads "pages 9c - 9f" should read "pages 9c - 9g"

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
\Medical Assistance Program

State/Territory GEORGIA

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TN No. 02-006
Supersedes Approval Date 2/11/0 3 Effective Date 12/1/02
TN No. 87-6

Citation

1.6 State Option for Managed Care

1932 of the Act
(BBA 1997)

Georgia Better Health Care (GBHC) is the Primary Care Case Management (PCCM) program for the State of Georgia. This program matches Medicaid recipients to a primary care provider (PCP) who, through an on-going provider/patient relationship, will provide and coordinate all health care services, including referrals for necessary specialty services, and maintain 24-hour availability to members. Enrollment with a PCP in GBHC is mandatory for all Medicaid recipients with the exception of those recipients listed in I.B. below. The objectives of this program are to improve access to medical care - particularly primary care services, enhance continuity of care through creation of a "medical home", and decrease cost through reduction of unnecessary medical services. Georgia Better Health Care operates as a statewide program. This proposed SPA will replace the current 1915(b) waiver program.

I. Assurances

A. The State of Georgia assures that all requirements under 1932 and 1905(t), and 42 CFR part 438, as applicable, will be met for the Primary Care Case Management (PCCM) program, Georgia Better Health Care (GBHC).

B. The State assures that the following populations will be exempt from enrollment in Georgia Better Health Care:

(1) Individuals who meet the eligibility requirements for receipt of both Medicare and Medicaid ("dual eligibles")
(2) American Indians who are members of a Federally-recognized tribe, and
(3) Children under 19 years of age who:

(a) are eligible for SSI under Title XVI
(b) are described in section 1902(e)(3) of Title XIX of the Social Security Act;
(c) are in foster care or other out-of-home placement;
(d) are receiving foster care or adoption assistance under part E of Title IV; or
(e) have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that generally required by children
(f) are receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V (**Children's Medical Services**).

Children's Medical Services, administered by the Georgia Division of Public Health, provides comprehensive, coordinated, Community-based, Title V services for children birth to 21 with chronic medical conditions. Medical eligibility includes, but is not limited to:

- burns
- cardiac conditions
- cystic fibrosis
- hearing disorders
- spina bifida
- cerebral palsy
- diabetes mellitus
- vision disorders

- craniofacial anomalies (including cleft lip/palate)
- gastrointestinal disorders
- neurological and neurosurgical conditions including epilepsy and hydrocephalus
- orthopedic and/or neuromuscular disorders (scoliosis)
- congenital or traumatic amputations of limbs

Identification for purposes of exemption will be accomplished by encounter and pharmacy claims analysis (high cost, high utilization, chronic disease diagnosis), recipient self-referral to Member Services or via referral by any provider or state agency on behalf of the recipient, new recipient questionnaire, and eligibility category. Upon confirmation of the child's exemption status, exclusion will be noted so the child will not be enrolled in Georgia Better Health Care. Upon notification that a GBHC enrolled child is in one of the excluded groups outlined above, that child will be disenrolled from GBHC with the appropriate exclusion code. Services for these children will not require prior authorization and emergency authorizations (EAs) will be provided for services rendered prior to the disenrollment date.

(4) In addition to those listed in B. (1), (2), (3) above, the State of Georgia will exempt the following populations from enrollment in GBHC
   (a) Residents of nursing homes, personal care homes or mental health hospitals or other domiciliary facilities;
   (b) Right from the Start Medicaid mothers;
   (c) Other recipients with short-term Medicaid enrollment; or
   (d) Recipients who have other Third Party Liability (TPL) coverage

C. Enrollment in Georgia Better Health Care is mandatory for the following Medicaid recipients:
   (1) Low income Medicaid adults
   (2) Low income Medicaid-related adults
   (3) SOBRA children
   (4) SSI recipients age nineteen (19) and above

D. Georgia Better Health Care is operational statewide. Individuals in every county have a choice of two (2) Georgia Better Health Care providers offering primary care case management services within their county of residence or adjacent counties. Potential enrollees and members will be required to select a PCP from a list of providers meeting this criterion. In rural areas, if only one PCCM group exists within the member service area, members will be given a choice between two providers within the PCCM group. If a selection is not made by the 15th of the month, the member will be assigned a primary care provider using the process outlined in section G below.

E. Georgia Better Health Care members are permitted to disenroll with a PCP at any time with cause. (Cause may be, but is not limited to: members who need covered Medicaid services that are not provided by the PCP on moral or religious grounds, poor quality care, lack of access to covered services, lack of access to experienced providers, the enrollee moves out of the PCPs service area.) Members will be allowed to request a change in PCP during the first 90 days of enrollment and at least every 12 months thereafter without cause.

F. Any GBHC member who is disenrolled from a PCP for any reason other than ineligibility for Medicaid will be immediately assigned to a different PCP using the process outlined in G below.

G. Georgia Better Health Care uses a default enrollment in the event the member does not choose a provider. The State assures that default enrollment will be based on maintaining existing as well as historical provider/member relationships to the extent possible. Members are given the opportunity to choose a primary care provider. If a selection is not made, a provider is auto-assigned to the member using an algorithm that ensures historical usage, family history, sex, age and geographic proximity. Historical usage is defined as one paid claim within the last 18 months from a provider. If the claims history shows the member has prior history with a PCP, the member is assigned to that provider. If no history with a PCP exists, a search is done for a family member's history with a PCP for assignment. Lacking any historical or family history, members are assigned to PCPs using an algorithm based on age, sex, geographic proximity, and in a manner that equitably distributes members among qualified PCCMs available. Members are notified of the auto-assignment and provided with a list of providers within the member's service area. If unhappy with an auto-assigned provider, a member may contact Member Services within the first 90-day period to request a change.

H. Potential enrollees and members are provided information for their service area, in an easily understood, comparative, chart-like format, that explains eligibility requirements and exclusions, provider and member rights and responsibilities, grievance, fair hearing and appeal procedures and timeframes, covered items and services and benefits that are not covered by Georgia Better Health Care, Primary Care Case Managers available, benefits, cost sharing (if applicable), non-English languages of service area providers, how to obtain services not provided by the PCP (including referrals to specialists) and, to the extent available, quality and performance indicators and member satisfaction information. This information will be available on enrollment, annually and on request. Member written materials will be available in English and Spanish and other prevalent languages identified within a service area. Primary language will be asked of members at the time of enrollment. Primary language and other languages spoken will be requested at the time of provider enrollment. Oral interpretive services for information in all languages can be obtained by calling the Customer Interaction Center. Providers will likewise be required to make written information available in the prevalent non-English language in its service area. Notification of how to access this information (regardless of format) will be available at enrollment locations, PCP offices, the State web site and other contacts as they are identified.

I. Access to medically necessary emergency services shall not be restricted. Emergency care means covered inpatient and outpatient services furnished by a qualified provider that are necessary to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. Treatment in emergency situations does not require prior authorization from the PCP or Georgia Better Health Care.

J. Georgia Better Health Care began on a limited basis in 1993. Prior to expansion to a statewide program in 1998, and through subsequent changes, public comment, from both providers and recipients, has been considered in the program design and implementation. Because this SPA will not constitute a change in the program, public notice to members did not occur. This conversion to Managed Care under the Georgia State Plan will be seamless to our members. Comments and feedback were solicited from the GBHC Advisory Committee members whose representation includes practicing providers from throughout the state. We also on an ongoing basis collect member feedback from the GBHC member services unit. Public notice of fee changes are done pursuant to policy as mandated by O.C.G.A. 350-2-.08. In the future, GBHC will continue to utilize providers from the various physician advisory committees, recipients currently involved in NET advisory committees, staff liaisons to advocacy groups that include both providers and recipients, and member satisfaction surveys in the ongoing development of the GBHC program.

II. Methodology and Process

Georgia Better Health Care operates a statewide network of providers with sufficient capacity available to ensure convenient geographic access, choice, and minimum travel times. Once eligibility is determined, beneficiaries are mailed informational materials regarding Georgia Better Health Care. Included is a list of 2 or more primary care providers located geographically convenient to the recipient. Recipients have until the 15th of a month to make a PCP selection. If no choice is made by the 15th, PCP assignment is completed through the auto-assignment process described in I.G. above. Members have the opportunity to change their PCP within the first 90 days of enrollment or reenrollment and at least annually thereafter. Members may change PCP at any time with cause. Members have access to a toll-free number for Member Services to assist with PCP selection, PCP changes and access issues that may occur. Periodic surveys are done to assess member satisfaction including travel time to the primary care provider office and wait times for scheduled appointments.

III. Contracts With Primary Care Providers

The State assures that contracts with Primary Care Providers are in compliance with the terms required under section 1905(t)(3) and 42 CFR part 438. These are non-risk contracts. Georgia Better Health Care PCCM providers are reimbursed on a fee-for-service basis, according to the regular Medicaid fee schedule when they render care to a member. In addition, they are paid a monthly case management fee for each assigned Georgia Better Health Care member for the purposes of coordinating members' health care services.

A. The following provider types may contract with the Georgia Better Health Care PCCM Program:

1. Physicians (doctors of medicine or osteopathy) practicing the following specialties: Family Practice, General Practice, Pediatrics, Internal Medicine and Gynecology

2. Licensed and Certified Advance Nurse Practitioners (ARNPs) specializing in Family Practice, Pediatrics or Gynecology. Nurse Practitioners in independent practice must also have a current collaborative agreement with a licensed physician who has hospital admitting privileges.

3. Other entities including Rural Health Centers, Community Health Centers, Primary Care Public Health Department Clinics and Primary Care Hospital Outpatient Clinics.

4. Physician specialists, public health departments, clinics and hospital outpatient clinics may enroll if they agree to meet the obligations of the PCP role, including the following conditions:

    1. Practice must routinely provide primary care services to a majority of its patients. Any exceptions to this requirement will be considered on a case-by-case basis for business need
    2. Any referrals for specialty care to other members of the same practice may be reviewed for appropriateness
    3. It is preferable that any specialist provider acting in a PCP capacity is willing to accept a minimum of fifty members to case manage.

In addition to the standard Medicaid provider agreement, all participating PCPs are required to complete an Application, Statement of Participation and an After-Hours Telephone Coverage & Provider Accessibility Agreement and successfully complete an on-site visit.

B. By contractual agreement the PCP agrees to the following PCCM Scope of Services:

1. The PCP is ultimately responsible for managing the total care provided to GBHC members, serving as the linkage between members and the various services along the health care continuum.
2. The PCP must provide or arrange PCP coverage for services – including treatment for emergency medical conditions, consultation or approval of referrals 24 hours a day, 7 days a week through access by telephone to a live voice.
3. The PCP must be available in the office to provide primary care services a minimum number of hours each week as specified in the current Part II, Policies and Procedures for Georgia Better Health Care Services.
4. The PCP may not refuse an assignment or disenroll a member or otherwise discriminate against a member on the basis of age, sex, race, color, national origin or an adverse change in the enrollee's health status or due to an enrollees utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment seriously impairs the PCPs ability to furnish services to either that enrollee or other enrollees or when that illness or condition can be better treated by another provider type. The PCP may not use any policy or practice that has the effect of discriminating on the basis of age, sex, race, color, national origin or an adverse change in the enrollee's health status or due to an enrollees utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment seriously impairs the PCPs ability to furnish services to either that enrollee or other enrollees or when that illness or condition can be better treated by another provider type.
5. The PCP must be able to manage elective hospitalizations for members in a manner that combines access to care with continuity. Therefore, a PCP must have hospital admitting privileges, or must have a formal arrangement with a physician who does have hospital admitting privileges and who agrees to abide by the established Georgia Better Health Care hospital authorization requirements.
6. Each PCP is required to specify the number of recipients the provider is will to serve as primary care provider. Unless circumstances exist that require authorization of a greater number to ensure adequate coverage in an underserved area, the upper limit for a physician, NP or PA, will be as designated in Part II, Policies and Procedures for Georgia Better Health Care Services. There is no minimum requirement except as listed in III.A.4.3. above.
7. PCPs must restrict enrollment to recipients who reside sufficiently near one of the PCPs delivery site to reach that site within a reasonable time using available and affordable modes of transportation.
8. The PCP must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to members promptly and without compromise to quality of care.